

# **HIV/AIDS AND SEXUALLY TRANSMITTED INFECTIONS (STIs) IN THE WEST BANK AND GAZA**

**Kai Spratt, R.N., M.P.H., Ph.D.  
HIV/AIDS and STI Technical Advisor  
Bureau for Asia and the Near East  
United States Agency for International Development**

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## ACRONYMS

DALY	Disability-adjusted life year
EHP	Expanded Health Program
FP	Family planning
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
IDU	Injecting drug use
IUD	Intrauterine device
MCH	Maternal and child health
MEDS	Monitoring, Evaluation and Design Support
MOH	Ministry of Health
SO	Strategic Objective
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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## **I. INTRODUCTION AND BACKGROUND**

The United States Agency for International Development (USAID) Mission in the West Bank and Gaza has concentrated its program in three strategic areas: expanded private sector economic opportunities, greater access to and more effective use of scarce water resources, and more responsive and accountable governance. Currently, the Mission is considering an additional area: reproductive and primary health and health policy. It has conducted a pilot activity in the health sector directed at maternal and child health and reproductive health in three distinct areas of the West Bank and Gaza (WB/G). In support of the design of a primary health program, the Mission requested assistance through the Monitoring, Evaluation and Design Support (MEDS) project to help conduct health sector assessments in two distinct geographic areas—the West Bank and Gaza—and to design a new Strategic Objective in health.

In February and March 2000, a team of MEDS consultants and USAID staff carried out the assessment and design work. An overall burden of disease assessment was conducted to identify and analyze priority health problems. This was supplemented by small, specialized assessments on nutrition and human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS).

Dr. Kai Spratt, HIV/AIDS, sexually transmitted infections (STIs), and reproductive health advisor to USAID's Bureau for Asia and the Near East, traveled to the West Bank and Gaza for two weeks in February 2000 to conduct the specialized assessment on HIV/AIDS and STIs.

### **BACKGROUND**

According to the latest Joint United Nations Programme on HIV/AIDS (UNAIDS) *AIDS Epidemic Update*, released in December 1999, approximately 33.6 million people worldwide are living with HIV/AIDS, of which 32.4 million are adults and 1.2 million are children under the age of 15 years. More than 16 million people are estimated to have died from AIDS since the beginning of the epidemic in 1981. Ninety-five percent of people living with HIV are in the developing world where poverty, poor sanitation, lack of access to health services, and low status of women contribute to the continuing spread of the infection.

The World Health Organization (WHO) ranks HIV/AIDS as the 27th leading cause of mortality for the Eastern Mediterranean region (0.4 percent of total mortality) and as the seventh leading cause of disability-adjusted life years (DALYs) for the region (2.8 percent of the total). UNAIDS has 10 world regions, of which the North Africa and the Middle East region ranks eighth in terms of HIV/AIDS prevalence, with approximately 220,000 adults and children living with HIV/AIDS and an adult prevalence of 0.13 percent (adults defined as 15–49 years of age) (UNAIDS, 1999). HIV infections first appeared in the region during the late 1980's, almost a decade behind Sub-Saharan Africa, Latin America, the Caribbean, Western Europe, North America, and Australia and New Zealand. Cases of HIV and AIDS have been reported from most countries in the region, including the West Bank and Gaza. The highest number of cases of AIDS has

been reported from Morocco (557) and Tunisia (519) (*Weekly Epidemiological Record*, WHO, November 26, 1999). While the majority of cases in the region are transmitted through heterosexual intercourse, in some Middle East countries, injecting drug use (IDU) accounts for a sizable proportion of infections: 67 percent of cases in Bahrain, 50 percent in Iran, more than 33 percent in Tunisia, and 10 percent in Egypt (UNAIDS, 1999). Surveillance data from the region that report just AIDS cases, however, underestimate the true prevalence of HIV infection which is many times higher than the number of reported AIDS cases.

The HIV situation in the Middle East is characterized by a general lack of data on

- rates of high-risk behavior among vulnerable populations, especially IDUs (extent of sharing of needles and syringes, practices of preparing drugs for use);
- sexual practices and networking among homosexuals and males who have sex with males (frequency of unprotected anal sex versus other sex, number of sexual partners, prevalence of STIs);
- the organization of the sex industry in a particular city or country (brothel based versus freelancing);
- kinds of sexual services provided by sex workers;
- average number of clients per day/week; and,
- the proportion of clients using condoms.

Epidemiological and prevention efforts are hampered by denial that risk behaviors occur within particular societies and the shame and stigma attached to the behaviors that put people at risk for the infection. Proxy indicators that indicate that high-risk behaviors are occurring in the societies of the Middle East are the high rates of hepatitis B, hepatitis C, and STIs that have the same risk behavior profile as HIV. UNAIDS (1999) estimates that about 10 million cases of STIs occur in the North Africa and Middle East region each year but fewer than 6 percent of the cases were reported in 1998. The highest rates occur among young adults and in urban areas.

## II. HIV/AIDS AND STIs IN THE WEST BANK AND GAZA

The West Bank and Gaza have traditional family structures, with conservative sexual and social values. It is also a country experiencing demographic and political transitions that have the potential to weaken the social control of sexual and other high-risk behaviors. Forty-four percent of the population is of reproductive age and 47 percent of the population is under the age of 15. The age of marriage is slowly increasing—18 years for women and 23 years for men. With the end of the Israeli occupation, there has been an increase in the number of men traveling into Israel for work and improved overall mobility. More than 50,000 Palestinians have returned from other Arab states and the West following the signing of the Oslo Accords in 1993 (Palestinian National Authority Ministry of Health, 1999). Unemployment remains high and economic opportunities, especially for women, are restricted. The use of alcohol, while generally low, is increasing, especially in refugee camps and the middle class. An unpublished study at Al-Quds University (1998) of 500 adolescents showed an increase in violence, drug use, smoking, and risk-taking behavior.

HIV spreads most rapidly into the general population under well-defined social and epidemiological conditions:

- multiple, concurrent sex partners by both men and women;
- unprotected anal sex;
- a high percentage of men visiting sex workers;
- brothel-based sex work;
- low-cost commercial sex;
- prevalent STIs, especially ulcerative STIs;
- sharing of injection equipment by injecting drug users; and,
- low condom use.

The majority of these factors do not appear to be prevalent in the West Bank and Gaza, although there is a paucity of reliable studies available. Prostitution is more prevalent in Israel and cities near the borders, although no reliable estimates of the number of prostitutes was available. Sex work did not appear to be brothel based, but it was reportedly inexpensive.

Fifty cases of HIV/AIDS have been detected in the West Bank and Gaza between 1988–99 (see table 1). The chief epidemiologist for the West Bank reported that all cases have been among Palestinians returning to Palestine from other Arab and Western countries. The overall prevalence is approximately 1.6 per 100,000. As of February 1, 2000, 33 cases of AIDS and 11 HIV-positive persons are registered in the West Bank and Gaza. Of the 33 AIDS cases, 29 (88 percent) of those infected are male; 48 percent contracted the virus through heterosexual intercourse, 24 percent through blood transfusions, 12 percent through unknown causes, 6 percent through multiple risk behaviors, and 3 percent each through homosexual relations, IDU, and mother-to-child transmission. (See table 2.) Eighty-six percent of HIV-positive males are between the ages of 15–49. (No data were available from the MOH on the routes of transmission for the 11 HIV-positive patients.)

**Table 1: Data for Persons with AIDS in the West Bank and Gaza**

Gender	Age	AIDS Cases		
		Number	Percent	Percent of Total (n=33)
Male	0–14 years	2	7%	6%
	15–49 years	25	86%	76%
	Over 50 years	2	7%	6%
	<b>Total</b>	<b>29</b>	<b>100%</b>	<b>88%</b>
Female	0–14 years	1	25%	3%
	15–49 years	2	50%	6%
	Over 50 years	1	25%	3%
	<b>Total</b>	<b>4</b>	<b>100%</b>	<b>12%</b>

*Source:* Palestinian National Authority Ministry of Health, *AIDS/HIV Surveillance Reports*, February 1, 2000

**Table 2: Modes of Transmission (All AIDS Cases)**

Mode	Percent
Heterosexual intercourse	48
Blood transfusions	24
Unknown causes	12
Multiple risk behaviors	6
Homosexual relations	3
Injecting drug use	3
Mother-to-child transmission	3
<b>Total</b>	<b>99 %</b>

*Source:* Palestinian National Authority Ministry of Health, *AIDS/HIV Surveillance Reports*, February 1, 2000

Data from the Palestinian National Authority Ministry of Health (2000) report no new cases among 27 individuals tested from high-risk groups (IDUs, blood recipients, sexual contacts of AIDS patients, prisoners, suspected AIDS patients, tuberculosis patients, and others) and no new cases among 33,142 individuals tested from low-risk groups (blood donors, pregnant women, out-migrants, premarital, and others). No data were available for STI patients, sex workers, bar girls, homosexuals, long-distance truck drivers, in-migrants, and voluntary testing and counseling centers (MOH categories).

More indicative of potential rates of high-risk behavior are data on STIs. During the last quarter of 1999, STI case reports based on syndromic management to the Ministry of Health record 50 cases of urethral discharge in men, 1,304 cases of vaginal discharge, 121 cases of genital ulcers (all women), and 359 cases of lower abdominal pain (women).

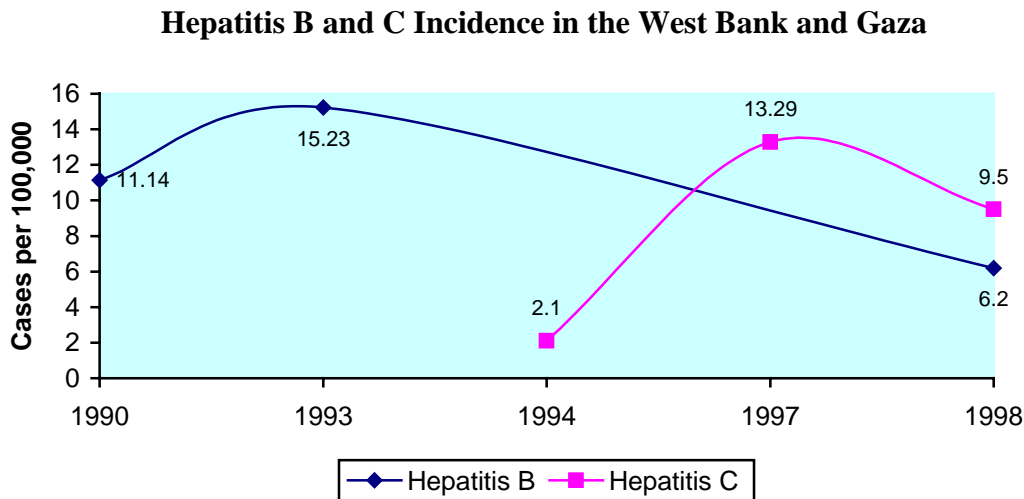
STI reports in the same period based on etiological diagnosis report no cases of syphilis, 6 cases of gonorrhea (5 men, 1 woman), 20 cases of non-gonococcal urethritis (4 men, 16 women), no cases of chancroid, 29 cases of trichomoniasis (14 men, 15 women), 390 cases of pelvic inflammatory disease, 3 cases of genital herpes (all women), and 25 cases of genital warts (all women).

These data underestimate the true prevalence of STIs in the West Bank and Gaza. Most private clinics do not report to the government. The national surveillance system needs strengthening. While syndromic management of STIs has been promoted in many resource poor countries, there are some weaknesses in this approach:

- Ineffectiveness of the syndromic algorithm for vaginal discharge for women (studies have shown that women with a discharge have only a slightly greater risk of actually having a cervical infection than women without a discharge;
- Even after training, medical staff fails to ask about symptoms, follow the recommended algorithms, prescribe appropriate drugs, provide counseling about prevention, provide condoms, or discuss partner notification; and,
- In typical family planning/maternal and child health (FP/MCH) settings relatively few women will present for STI treatment and often those who do are less likely to pass the infection to multiple other partners (*Integration of Family Planning/MCH with HIV/STD Prevention: Programmatic Technical Guidance*, USAID 1998).

Even with limited clinical facilities within the West Bank and Gaza for etiological diagnosis of STIs, anecdotal reports suggest that the majority of persons suspecting that they have an STI go to private practitioners or pharmacies for treatment, often in a different village or town than where the person lives, rather than visit a public health clinic.

Data available from the Palestinian National Authority Ministry of Health for hepatitis B and C incidence indicate the level of potential risk for other sexually transmitted infections in the West Bank and Gaza (see figure below). Between 1990 and 1998, hepatitis B prevalence has ranged from 11.14 per 100,000, to a high of 15.23 per 100,000 in 1993, and decreased to 6.20 per 100,000 in 1998. The rate for hepatitis C was very low in 1994 (the first year in which data were available), increased more than sixfold in 1997, and then decreased to 9.5 per 100,000 in 1998.





### **III. CURRENT EFFORTS IN THE WEST BANK AND GAZA TO ADDRESS HIV/AIDS AND STIs**

The Ministry of Health is undertaking notable HIV and STI prevention efforts in the Palestinian Territory. Since 1994, given the large percentage of HIV cases contracted through blood transfusions, all donated blood has been screened for HIV as well as for hepatitis B and C. The use of print, radio, and television media to educate the public about HIV/AIDS and STIs has been authorized by the Palestinian National Authority for several years. The government has also supported school-based HIV/AIDS and STI prevention education activities, despite resistance in some communities. In 1998, the government set up STI units at the MOH for screening, treatment, and counseling. The MOH provides free or low-cost treatment to all patients with STIs and antiretroviral therapy to HIV-positive persons.

Condoms are available in both MOH and donor-funded clinics as a family planning option, along with intrauterine devices (IUDs) and oral contraceptives. According to clinic staffs, the majority of patients at these clinics are women who ask for condoms for family planning purposes, not for HIV/AIDS prevention (although embarrassment may limit direct requests in this case because condom use, even for family planning, is very low [about 3 percent], which is consistent with other countries in the region). Condoms are also readily available in pharmacies in urban areas; five brands were found in one pharmacy in Ramallah, costing approximately 1 shekel (25 cents) per condom.

There is one referral laboratory for HIV/AIDS testing in the West Bank but there are no anonymous voluntary counseling and testing facilities in the Territory. (There is an anonymous counseling and testing facility in the Israeli sector of Jerusalem at Hadassah Medical Center.) Anecdotal reports from a private laboratory in Ramallah revealed very few requests for HIV testing; comprehensive counseling is not available at private laboratories.

The government's approach to case finding for HIV testing is problematic. Using the police to identify high-risk persons (especially IDUs and sex workers) rather than having community-based organizations conduct anonymous outreach and education activities, threatens to keep those at risk unknown.

#### **IV. CONCLUSIONS AND RECOMMENDATIONS**

While the overall picture for continued low levels of HIV/AIDS and STI prevalence looks encouraging, complacency must be avoided. Any escalation in the number of cases of HIV/AIDS, given the government's funding for treatment, could result in a serious burden on the health care budget. Although the current costs in the Palestine Authority are unknown, the annual cost of antiretroviral medications is \$4,000 per HIV case in Brazil (*AIDS Epidemic Update*, 1999) and \$10,400 in the United States (Centers for Disease Control and Prevention, 1997).

At this point, it is not recommended that the Mission put substantial resources into a separate, independent HIV/AIDS prevention program. There are opportunities to fold HIV/AIDS education and prevention efforts into the Pilot Health Project and into the pending Strategic Objective (SO) 7's Expanded Health Program (EHP) activities. It is strongly recommended that adolescent and male health components, which should include HIV/STI prevention education and awareness, be included in EHP activities. There are also opportunities to include a component of HIV/AIDS and STI education and awareness across Mission sectoral activities, that is, into education and/or democracy and governance activities. The latter is important because the government's current strategy of targeting high-risk groups for HIV testing has the potential of violating an individual's rights of refusal to be tested and rights to privacy, which is a strong deterrent, along with social discrimination and stigma, to avoid seeking HIV testing or care.

#### **RECOMMENDATIONS**

- Truly anonymous voluntary testing and counseling centers need to be established in the Palestine Territory. Blinded data can be provided to the MOH while persons who test positive can determine for themselves if they want to self-identify in order to access treatment. The Mission could provide training for center staff in voluntary counseling and testing ethics and methods.
- Voluntary testing and counseling should be provided to all Palestinians returning from abroad. While mandatory testing is politically sensitive and ethically questionable, voluntary testing provides an opportunity for further prevention and treatment.
- Health care workers at all levels need HIV/AIDS and STI education and awareness training to mitigate their own fear, negative attitudes, and misinformation about people with HIV/AIDS and STIs.
- Health care workers need training to improve their counseling and training in issues pertaining to sexual and reproductive health and STIs.
- Strengthening the national surveillance system for all reportable diseases should be a priority activity under SO7. This would improve data available on HIV and STIs as well.

- Public health education must focus on tolerance and prevention and must not be based on fear, which promotes denial of individual risk and increases stigmatization and discrimination of those who are HIV positive. Health messages should also inform people of what to do and where to go if they think they have a sexually transmitted infection.
- The Pilot Health Project may want to conduct a trial of providing Men's Health Night at a few clinics to encourage men's use of health services. While avoiding advertising the nights for HIV/AIDS and STI information and treatment, these activities would be available. Condoms should be easily accessible throughout the clinics on these nights.
- Continue to provide sexual/physical health education to youth, for children both in and out of school. Work with committees of parents and religious leaders to find the appropriate approach and frame it in terms of family protection. Collaborate with other donors, especially UNICEF, which is launching a new adolescent health program, to share strategies and avoid duplication.
- Work with NGOs willing to provide outreach to risk groups (although these groups are very small). Work with the MOH to change its policy/approach of having police find high-risk groups.
- Continue to educate health center staffs on universal precautions. Visits to one donor-funded clinic in the Gaza Strip revealed that there was no "sharp box" available and we were told staff routinely recap used needles. Gloves were available.
- Condoms are available in clinics and pharmacies but more venues need to be available, such as grocery stores and street vendors.
- The USAID Mission in Tel Aviv may want to explore the potential for regional collaboration to conduct formative and operations research on sensitive issues, such as males who have sex with males and other high-risk groups, and with the Missions in Egypt and Jordan and the Asia and the Near East Bureau's Regional HIV/AIDS program.

## **APPENDICES**

### **A: PERSONS CONTACTED**

### **B: REFERENCES**

## **APPENDIX A**

### **PERSONS CONTACTED**

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### **USAID/Tel Aviv, Israel**

Larry Garber  
Mission Director

Jack Thomas, M.P.H.  
Health Technical Advisor

Taroub Harb-Faramand, M.D., M.P.H.  
Health and Population Advisor

Thomas H. Staal  
Office Director

Bassam Kort  
Program Specialist

Nimalka Wijesoorijya  
Controller

Tim Beans  
Contracting Officer

Peter Malnak  
Project Development Officer

### **Palestinian National Authority Ministry of Health**

Dr. Riyad Al-Za’Noun  
Minister of Health  
Gaza

Dr. Nadim Toubassi  
Director General, Ministry of Health  
Primary Health Care and Public Health

Dr. As’ad Ramlawi  
Director, Preventive Medicine

Ousama A. Salah, M.D.  
Nutritionist  
Director of Nutrition Unit  
Ramallah, West Bank

Dr. Souzan Ahmad Abdo  
Directory of Women’s Health and  
Development

### **Al-Quds University**

Ziad Abdeen, Ph.D.  
Dean of Research and Graduate Studies

Mounira W. Qleibo, Rd., M.Sc.  
Researcher

### **UNICEF, Jerusalem**

Marilena Viviani  
Special Representative  
West Bank and Gaza

Dr. Nadim Al-Adili  
Health Program Officer

### **WHO**

Paola Piva, M.D.  
WHO Health Coordinator  
Jerusalem

### **Union of Health Work Committee**

Dr. Rahab H. Mohanna  
Chairman and Endocrinologist Consultant  
Gaza

Dr. Mona El-Farra  
Head of Community Programs  
Gaza Strip—Gaza, El Jala’ Al,  
El Wehda Cross

Dr. Mahmoud Abo El-Kheir  
Deputy Director  
Gaza Strip, Gaza

## **Other Organizations**

Nidal H. Harb, M.D.  
Harb Heart Center  
Ramallah, West Bank

Dr. Bashar Al-Karmi  
General Manager  
Medi-Care  
Ramallah, West Bank

Edward Green, Ph.D.  
Consultant in International Development

Suzy A. Srouji, M.D., M.P.H.  
CARE  
Ramallah, West Bank

Donatella Linari  
EU Representative  
Health Expert  
MEDA TEAM  
West Bank and Gaza

Umaiye M. Khammash, M.D., M.P.H.  
Chief, Field Health Programme  
West Bank, UNRWA

Henry D. Kalter, M.D., M.P.H.  
Assistant Scientist  
Johns Hopkins School of Hygiene and  
Public Health  
Department of International Health

Rita Giacaman, Pharm.D., M.Phil.  
Director  
Institute of Community and Public Health  
Bir Zeit University

Earl Wall  
West Bank/Gaza Country Director  
CARE

## **APPENDIX B**

## **REFERENCES**



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